

MED - Home Health Retrospective Review Data Pull and Documentation Request Process

Purpose: To review Home Health documentation and ensure that services are provided to Medicaid members within the rules of the Medicaid program as described in the Iowa Administrative Code (IAC) and that the documentation is consistent with Medicaid requirements. Medical Services will recoup funds from the Home Health provider for services that are not medically necessary or do not meet the requirements for documentation as outlined in IAC.

Identification of Roles:

Manager – facilitates obtaining data

Review Assistant (RA) – provides program support through coordinating documentation request letters and supporting review coordinators with accessing information required to complete Home Health retro reviews.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: Through e-mail managers receive a monthly data pull from data warehouse by the third business day of the month e.g. at the beginning of February the paid claims for January will be received.

Step 2: Following are the criteria for the data pulls:

1. HHRetro data pull:
 - a. Outpatient claims UB04
 - b. Provider type 09 (home health)
 - c. Exclude:
 1. Claims with type-bill (TOB) 342
 2. Claims with procedure codes S9122-S9124 these are claims that require a PA Claims with only REV code 57X with X number of units
 3. Claims with only REV code 57X with X number of units and REV code 55X with a total units less than or equal to two units.
 4. Claims with procedure code T1000 with REV code 559. Procedure code T1000 requires a prior authorization.
 - d. Once the above claims have been excluded, INCLUDE only claims that meet the following criteria:
 1. Have more than five units of REV code 55X SN;
 2. Have more than 15 units of REV code 57X home health aide;
 3. Have REV code 42X physical therapy;
 4. Have REV code 43X occupational therapy;
 5. Have REV code 44X speech-language therapy; or
 6. Have REV code 56X medical social services

- e. Out of the claims that are left, 175 randomly selected claims for Retrospective Home Health are sent to Medical Services for review. The following information is included in the spreadsheet sent to Medical Services from Data Warehouse:
 1. TCN
 2. Member State Identification Number (SID)
 3. Member Name
 4. Member date of birth
 5. Date of Service (COV-PERIOD)
 6. Treating Provider NPI and legacy Identification (ID)
 7. Treating provider name
 8. Treating provider's correspondence address
 9. TYPE-BILL
 10. REV codes billed
 11. Number of units billed for each REV code
 12. Submitted charge (Total)
 13. Medical allowed charge (dollar amount paid on the claim)
2. PDN PC data pull
 - a. Outpatient claims UB04
 - b. Provider type 09 (home health)
 - c. Include only claims that meet the following criteria:
 1. Have procedure code S9122, S9123, or S9124 or
 2. Have REV codes 552, 562, or 572;
 3. These do not have to be the only codes on the claims, but claims must include one of the procedure codes or one of the REV codes
 - d. Out of the claims that are left, 15 randomly selected claims for Retrospective Private Duty Nursing regarding EPSDT (Early Periodic Screening, Diagnosis, and Treatment) are sent to Medical Services for review. The following information is included in the spreadsheet sent to Medical Services from Data Warehouse:
 1. TCN
 2. Member State Identification Number (SID)
 3. Member Name
 4. Member date of birth
 5. Date of Service (COV-PERIOD)
 6. Treating Provider NPI and legacy Identification (ID)
 7. Treating provider name
 8. Treating provider's correspondence address
 9. TYPE-BILL
 10. REV codes billed
 11. Procedure codes billed
 12. Number of units billed for each REV code
 13. Submitted charge (Total)
 14. Medical allowed charge (dollar amount paid on the claim)

Step 5: The manager notifies review assistant (RA) that the data pull has been received and saves pull on the spreadsheet located on the Med Srv:/Medical Support/Home Health Providers folder as (Month) (Year) Data Pull.

Step 6: The RA reviews data pull, verifying provider name, address and information is complete.

- a. If necessary the RA will fill in any information that is blank by utilizing the provider information from Medicaid Management Information System (MMIS).

Step 7: The RA runs the Home Health Retrospective Medical Review Request for Records letter and Home Health Retrospective Medical Review Face Sheet document and mails both to the providers of the randomly selected claims. This process is completed monthly.

Step 8: The RA runs the Private Duty Nursing Retrospective Medical Review Request for Records letter and Private Duty Nursing Retrospective Medical Review Face Sheet document and mails both to the providers of the randomly selected claims. This process is completed quarterly.

Forms/Reports:

Home Health Retrospective Medical Review Request for Records

<<Date>>

<<Provider Name>>

<<Provider Address>>

<<City>>, <<State>> <<Zip>>

RE: Home Health Services Program- Retrospective Medical Review

Dear Provider:

Provider NPI: <<Provider NPI>>

Iowa Medicaid Enterprise (IME) systematically reviews documentation maintained by home health agencies to ensure that services are provided to Medicaid members within the rules of the Medicaid Program as described in Iowa Administrative Code 441-78.9. Your claim(s) for a Medicaid member(s) has been randomly selected for Home Health Services- Retrospective Medical Review (HHS- RMR). Attached you will find an HHS- RMR Face Sheet for each member detailing the specific date of service and claim information selected for review.

Please submit the following documentation for each member identified on the attached HHS- RMR Face Sheet(s) within 30 days of the date of this letter:

- The HHS- RMR Face Sheet included with this letter
- The most recent OASIS assessment for the billing period (i.e.: Start of Care, Resumption of Care, or Recertification OASIS)
- The Plan(s) of Care covering the billing period
- Any applicable supplemental physician orders obtained from the physician related to the billing period
- Progress notes for all Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Worker, and Home Health Aide services provided during the billing period

Please affix the HHS- RMR Face Sheet for each Medicaid member to the **FRONT** of the requested documentation for that member. The above listed documentation may be faxed to IME at (515) 725-1355 using the HHS- RMR Fax Cover Form 470-4687 or mailed to the address identified below:

**Iowa Medicaid Enterprise
Medical Services
P.O. Box 36478
Des Moines, IA 50315
Attention: Home Health Retrospective Medical Review**

Failure to submit requested documentation **within 30 days** will result in a technical denial and recoupment of reimbursement.

Following the retrospective review of the record, you will be notified in writing, of one of the following:

- Confirmation of accurate claim reimbursement
- Request for additional documentation
- Notification of claim overpayment and necessary recoupment based upon medical record documentation submitted

If you have any questions, please contact Medical Services by calling 800-383-1173, or locally (515) 256-4623. If you are submitting documentation by fax, please attach the HHS- RMR Fax Cover Form 470-4687 that can be found at <http://www.ime.state.ia.us>, click on Providers, Forms.

Medical Services Home Health Retrospective Medical Review Face Sheet

**Iowa Department of Human Services
Iowa Medicaid Enterprise – Medical Services
Home Health Services Program
Retrospective Medical Review Face Sheet**

<<Request Date>>

****Failure to submit the face sheet and requested home health services (HHS) documentation within the specified time frame will result in a technical denial.****

<<Provider Name>>

<<Provider Address>>

<<City>>, <<State>> <<Zip>>

PLEASE NOTE:

REQUESTED HOME HEALTH SERVICES (HHS) PROGRAM DOCUMENTATION IS DUE 30 DAYS FROM DATE ON FACE SHEET.

Please affix the HHS- RMR Face Sheet to the **FRONT** of the requested information for that specific Medicaid member. You may fax this information to IME at 515-725-1355 using the HHS- RMR Fax Cover Form 470-4687 that can be found at <http://www.ime.state.ia.us>, or mail to the address identified below:

**Iowa Medicaid Enterprise
Medical Services
P.O. Box 36478
Des Moines, IA 50315
Attn: HHS- RMR**

**NPI Number: <<Provider NPI>>
Member Name: <<LastName>>, <<FirstName>>
Date of Service: <<FirstDOS>> - <<LastDOS>>
TCN: <<TCN>>**

**Member ID#: <<StateID>>
Member DOB: <<DOB>>
Submitted Charge: <<SubmitChrg>>
Allowed Charge: <<AllowChrg>>**

If you have any questions please feel free to call 1-800-383-1173 or locally (515) 256-4623.

Medical Services Retrospective Private Duty Nursing/Personal Cares Request for Records Letter

<<Date>>

«prov_name»

«performing_provider_address_1»

«performing_provider_address_2»

«performing_provider_city», «performing_provider_state» «performing_provider_zip»

RE: Private Duty Nursing/Personal Cares- Retrospective Medical Review

Dear Provider:

Provider NPI:

«performing_provider_npi»

Iowa Medicaid Enterprise (IME) systematically reviews documentation maintained by home health agencies to ensure that services are provided to Medicaid members within the rules of the Medicaid Program as described in Iowa Administrative Code 441-78.9. Your claim(s) for a Medicaid member(s) has been randomly selected for Private Duty Nursing/Personal Cares- Retrospective Medical Review (PDN/PC-RMR). Attached you will find an PDN/PC-RMR Face Sheet for each member detailing the specific date of service and claim information selected for review.

Please submit the following documentation for each member identified on the attached PDN/PC-RMR Face Sheet(s) within 30 days of the date of this letter:

- The PDN/PC-RMR Face Sheet included with this letter
- The most recent assessment for the billing period (i.e.: Start of Care, Resumption of Care, or Recertification)
- The Plan(s) of Care covering the billing period
- Any applicable supplemental physician orders obtained from the physician related to the billing period
- Progress notes for all Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Worker, and Home Health Aide services provided during the billing period

Please affix the PDN/PC-RMR Face Sheet for each Medicaid member to the **FRONT** of the requested documentation for that member. The above listed documentation may be faxed to IME at (515) 725-1355 using the PDN/PC-RMR Fax Cover Form 470-4973 or mailed to the address identified below:

**Iowa Medicaid Enterprise
Medical Services
P.O. Box 36478
Des Moines, IA 50315
Attention: Home Health Retrospective Medical Review**

Failure to submit requested documentation within 30 days will result in a technical denial and recoupment of reimbursement.

Following the retrospective review of the record, you will be notified in writing, of one of the following:

- Confirmation of accurate claim reimbursement
- Request for additional documentation
- Notification of claim overpayment and necessary recoupment based upon medical record documentation submitted

If you have any questions, please contact Medical Services by calling 800-383-1173, or locally (515) 256-4623. If you are submitting documentation by fax, please attach the PDN/PC-RMR Fax Cover Form 470-4973 that can be found at <http://www.ime.state.ia.us>, click on Providers, Forms.

Medical Services- Home Health Retrospective Medical Review
Iowa Medicaid Enterprise

Forms/Reports:

N/A

RFP Reference:

6.2.1
6.2.1.1
6.2.1.2
6.2.1.3

Interfaces:

OnBase

Attachments:

N/A

MED - Home Health Retrospective Review Documentation Receipt and Logging Process

Purpose: The RA receives Home Health documentation and logs it for the RC to review to ensure that the services are provided to Medicaid members within the rules described in IAC. The RC ensures that the documentation is consistent with Medicaid requirements.

Identification of Roles:

Review Assistant (RA) – provides program support through coordinating documentation request letters and supporting RCs with accessing information required to complete home health retro reviews.

Performance Standards: N/A

Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The RA receives the requested documentation by mail and will fax it into the Med07 HH Retro Review queue or it will be faxed directly into medical services by the provider.

Step 2: In the Med07 HH retro review queue the RA will keyword the documentation and enter the DCN and received date into the home health retro database spreadsheet stored in the Medical Services R:/Medical Support/Home Health Provider/HHRetro DB, Access Database.

Step 3: When the document has been keyworded and logged in the database, the RA will complete the document and move it to the MED07 HH retro review hold for the RC to complete the review.

RFP Reference:

6.2.1
6.2.1.1
6.2.1.2
6.2.1.3

Interfaces:

OnBase

Attachments:

N/A

MED - Home Health Retrospective Review of Documentation

Purpose: Review Home Health services and ensures the services and documentation is consistent with Medicaid requirements.

Identification of Roles:

Review Coordinator (RC) – reviews documentation to determine if the home health services were provided within the rules of the Medicaid program or if payment needs to be recouped from the provider.

Review Assistant (RA) – provides program support through coordinating documentation request letters and supporting RCs with accessing information required to complete home health retro reviews.

Performance Standards:

Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The RC receives the requested documentation in the MED07 home health retro review hold queue and finds the correlating database record in the home health retro data base.

Step 2: The RC reviews the Outcome and Assessment Information Set (OASIS) assessment, physician orders, progress notes, plan of care, billing, and for medical necessity on the plan of care:

Step 3: Review of the Plan of Care:

- a. Determine if there is a plan of care present to cover the billing period. There may be only one 60 day plan of care in which the billing period is included or there may be two plans of care necessary to cover the entire month billed.
 1. For example: If plan of care ends in middle of month, two plans of care will be submitted with the claim.
- b. If plan(s) of care are not submitted, deny using recoupment reason 4.
- c. Determine that a physician has signed plan of care. This should be in Locator 27.
- d. Locator 25 is area for agency to type in physician's name and address; locator 27 is the area to check for handwritten or electronic signature from physician.
 1. It is acceptable for physician to sign only one of the pages.
 2. Physician does not have to sign all pages if plan of care is multiple pages long.
 3. The date of the physician signature must be within the certification period.
 4. If plan of care has not been signed, deny using recoupment reason 5.

5. If physician signature is not within certification period, deny using recoupment reason 6.

Step 4: Review of physician orders for visits billed:

- a. Determine what disciplines have been billed and number of visits billed for each discipline.
 1. 270: Supplies
 2. 420: Physical therapy
 3. 430: Occupational therapy
 4. 440: Speech Therapy
 5. 550: Skilled Nursing (SN)
 6. 560: Medical social worker
 7. 570: Home Health Aide
- b. Compare orders for visits location 21 of plan of care to what has been billed.
- c. Use calendar to determine if frequency billed matches order.
- d. Keep in mind that some agencies begin their week on Sundays, some on Mondays. This may be written on location 21 at the beginning of the section.
- e. Orders for visit frequencies can change. There must be a supplemental physician order reflecting this change. Always figure at the highest frequency if a range is given.
 1. For example, five to seven times per week, use the seven times per week.
- f. If the visits billed exceed the frequency for the physician orders, deny using recoupment reason 8.
- g. If physician orders are not found that cover billed visits, deny using recoupment reason 9, 21, 25 or 29.
- h. If SN visits exceed five visits per week (exception of daily Insulin administration or daily wound care), without exception to policy, deny using recoupment reason 14.
- i. For aide visits, the frequency, duration and number of hours per visit must be included in the orders. Services by aide are not to exceed 28 hours per week under intermittent Medicaid.
- j. If frequency, duration and number of hours are missing, deny using recoupment reason 7.
- k. If home health aide visit hours exceed 28 hours per week, deny using recoupment reason 19.
- l. For therapy orders (PT, OT, and ST), an order for the therapist to evaluate and treat is only sufficient for a one time evaluation visit.
- m. There must be documentation with physician signature that orders were obtained for continued ongoing therapy visits.
 1. For example: Two week six (two visits per week for six weeks).

Step 5: Review of supplies:

- a. Agencies are limited to supplies of no more than \$15.00 per month.
- b. If the supply charge (REV code 270) exceeds \$15, modify using recoupment reason 3.

Step 6: Review of OASIS assessment

- a. Determine that appropriate OASIS assessment has been submitted.
- b. If the billing period is for new start of care, there should be a start of care OASIS.
- c. If patient has recently been hospitalized, there should be resumption of care OASIS.
 1. If the member is on continued service.

2. For example, past the initial 60 day certification period there should be a recertification OASIS.
- d. Sections of the OASIS assessment to review include:
 1. MO 230 primary code diagnosis this should be the primary reason that member requires home care services.
 2. MO250 therapies if SN is ordered for IV therapy, Total Parenteral Nutrition (TPN), or enteral therapy, this section should be marked appropriately.
 3. MO 390 vision if member is receiving visits due to impairment of vision registered nurse (RN) to set up meds or fill syringes, or aide for personal care, this section should be marked as 1 or 2.
 4. MO 420 frequency of pain if member is receiving SN to assess pain or therapy to treat pain, such as heat or TPN, this section should be marked 2 or 3.
 5. MO 460, 476, or 488 wounds if SN is ordered to perform wound care, there should be a description of the number of wounds, the stage of the pressure ulcer, if present, the size of the wound, and whether the stasis ulcer or surgical wound is or is not healing.
 6. MO 490 dyspnea, if SN is ordered to monitor and assess member's respiratory status, this section should be marked 2, 3 or 4.
 - i. For example, dyspnea with at least moderate exertion or worse.
 7. MO 530 or 540 urinary or bowel incontinence, if SN or aide visits are ordered due to incontinence, MO 530 should be marked as 1 or 2 and MO 540 should be marked as 2 or higher.
 8. MO 550 ostomy, if SN or aide visits are ordered related to ostomy care, this section should be marked as 1 or 2.
 9. MO 650, 660, 670, 680, 690 and 700 these OASIS sections describe the member's functional abilities.
 - i. Determine how much assistance member needs with dressing, bathing, toileting, transferring and ambulation to support necessity for aide as well as physical and occupational therapies.
 10. MO 650 and 660 should be marked 1 or greater.
 11. MO 670 should be marked 2 or greater.
 12. MO 680 should be marked 2 or greater.
 13. MO 690 should be marked 1 or greater.
 14. MO 700 should be marked 1 or greater.

Step 7: Discipline Visit Progress Notes Compare documented services provided to:

- a. Modalities ordered in section 21 of plan of care to determine if physician orders are being carried out.
- b. OASIS assessment to determine if the description of the member's status on the visit matches the OASIS assessment.
- c. Goals on plan of care to determine if progress is made toward achievement of goals.
- d. Determine rehab potential of member.

- e. If rehab potential is documented as poor, question length of time therapy has been providing service and if services are repetitive and if limited progress is documented.

Step 8: Review of Medical Necessity:

- a. Criteria for determining medical necessity will be determined by using the following references:
 - 1. Medicaid home health services provider manual
 - 2. CMS home health care guidelines
- b. The following are guidelines of criteria indicating the medical necessity for the discipline and/or services provided:
 - 1. Home Health Aide
 - i. The member must require assistance with personal care (ADLs', bathing, transfers, hair care, oral care, exercises, reminding them to take meds). Transportation and homemaking services are not coverable.
 - ii. If documentation in the OASIS or aide visit progress notes does not support the medical necessity of home health aide services, deny using recoupment reason 18. If visit progress notes are missing for billed aide visits, deny using recoupment reason 20.
 - 2. Skilled Nursing-
 - i. The member should require skills of a nurse to:
 - 1. Observe and assess (when likelihood that members condition might change, when medications are being adjusted or changed, when members condition is not stable)
 - 2. Manage and evaluate the care plan (to ensure essential non-skilled care is achieving its' purpose) often, there are multiple care providers involved in members care.
 - 3. Teach or train member. Teaching should not be repetitive.
 - 4. Teaching is also not reasonable if patient or family incapable of learning due to cognitive impairments.
 - 5. Give meds (IV, IM or SQ)
 - 6. Insert or change catheters
 - 7. Perform wound care
 - 8. Teach or perform ostomy care
 - 9. Perform venipunctures
 - 10. Tube feedings
 - 11. Tracheotomy care
 - ii. Determine if service requires skills of a nurse based on complexity of service and the condition of the member.
 - 1. For example, member has preexisting medical condition such as diabetes or circulatory impairment that requires skills of nurse to assess and monitor member.
 - iii. If SN visit progress notes are missing for billed SN visits, deny using recoupment reason 15.
 - iv. If documentation in OASIS and /or SN notes does not support the medical necessity of SN visits.

1. For example, to observe, assess, monitor, teach or perform a skilled procedure, deny using recoupment reason 16 or 17.
3. Physical Therapy:
 - i. The member should require therapy to:
 1. Assess or reassess member rehab needs
 2. Test or measure range of motion
 3. Test/measure strength
 4. Test balance
 5. Test coordination
 6. Test endurance
 7. Assess member's functional abilities
 8. Develop and/or teach home exercise program, perform therapeutic exercise
 9. Gait training
 10. Perform range of motion
4. Maintenance therapy to maintain function for members with chronic conditions (Parkinson's, Rheumatoid Arthritis)
 - i. Ultrasound, shortwave or diathermy treatments
 - ii. Hot packs, infra-red, paraffin baths and whirlpool baths.
 - iii. If PT visit progress notes are missing, deny using recoupment reason 22.
 - iv. If OASIS and/or PT progress notes do not support the medical necessity of PT visits, deny using recoupment reason 24.
 - v. If documentation supports member has reached their maximum rehab potential or has poor rehab potential, deny using recoupment reason 23.
5. Speech Therapy
 - i. The member should require speech therapy to:
 1. Assess or reassess members rehab needs
 2. Restore function resulting in impaired communication (disorders of voice, fluency, articulation, language, or swallowing disorders)
 3. Aural rehab (speech reading or lip reading to members with hearing loss)
 4. Teaching sign language and/or teaching use of augmentative communication device.
 5. If speech therapy progress notes are missing, use recoupment reason 30.
 6. If OASIS and /or speech therapy visit progress notes do not support the medical necessity of speech therapy visits, the member has reached maximum rehab potential, or has poor rehab potential; deny using recoupment reason 31 or 34.
 7. If no material improvement is documented in the member's communication ability, deny using recoupment reason 32.
 8. If group Speech Therapy or audiology services related to use of a hearing aid are provided, deny using recoupment reason 33.
6. Occupational Therapy

- i. The member should require occupational therapy to:
 - 1. Assess or reassess members rehabilitation needs
 - 2. Improve or restore function with therapeutic activities
 - 3. Teaching ways to improve independence/compensatory techniques in activities of daily living (ADLs).
 - 4. Design, fabricate and fit orthotic devices
 - 5. Assess and train member on adaptive equipment
 - 6. Teach energy conservation techniques
 - 7. Design and train on maintenance program and periodic evaluation of effectiveness of program.
 - 8. If OT visit progress notes are missing, deny using recoupment reason 26.
 - 9. If OASIS and/or OT visit progress notes do not support the medical necessity of billed OT visits, deny using recoupment reason 28.
 - 10. If documentation supports member has poor rehab potential or has reached maximum rehab potential, deny using recoupment reason 27.
- 7. Medical Social Worker
 - i. The member should require medical social worker to:
 - 1. Assess and address social problems that are impeding the member's recovery.
 - 2. Assess and resolve emotional problems that are impeding the member's recovery.
 - 3. Assess relationship of member's medical & nursing requirements to member's home situation, financial resources and if necessary community resources are in place.
 - 4. Assist in obtaining community resources for member.
- 8. Counseling service
 - i. If OASIS and/or medical social worker visit progress notes do not support medical necessity of social worker billed visits, deny using recoupment reason 35.
 - ii. There must be evidence of social or emotional factors that are adversely affecting the member's recovery.
- 9. Supervisory Visits
 - i. If member is only receiving aide services i.e., no skilled services are provided, there must be evidence that a RN is conducting a supervisory visit a minimum of every 60 days. If not, deny using recoupment reason 12.
 - ii. If member is receiving aide services as well as skilled services, there must be evidence that a nurse is conducting a supervisory visit every two weeks. If not, deny using recoupment reason 11.

Step 9: Review of Billing Revenue codes/Charges per visit

- a. All discipline visits are to be billed at visit rates. If visits are billed at hourly rates, or in time increments, deny using recoupment reason 2.
- b. Intermittent Medicaid visits are to be billed with following Rev codes:
 - 1. 270 Supplies

2. 420 Physical Therapy
3. 430 Occupational Therapy
4. 440 Speech Therapy
5. 550 SN
6. 560 Medical Social Worker
7. 570 Home Health Aide

c. If hourly Rev codes are used, deny using recoupment reason 2.

Step 10: Following the review if the RC determines the services provided are within Medicaid guidelines, the 'No Issues Noted' review letter type is marked in the home health retro data base.

a. Allowed units, outcome, and any comments are entered in the database.

Step 11: If following the review, the RC determines the services provided are not within the Medicaid guidelines, the 'Recoupment Need Identified' review letter type is marked in the home health retro data base.

a. The RC will enter the recoupment amount, allowed units, outcome, rationale, and comments are entered in the database.

Step 12: On a weekly basis RA sends the 'No Issues Noted' or 'Recoupment Need Identified' letters and report via USPS mail to providers providing the initial review results.

Step 13: If the documentation originally requested is not received within 30 days of the request, the RA sends a final request for documentation and face sheet to the provider allowing an additional 15 days to submit the requested documentation.

Home Health Retro Database

Home Health Retrospective Review Recoupment Reasons

- a. No concerns.
- b. Visits were billed at an hourly rate or with an incorrect revenue code. IAC 78.9(249A)
- c. Supply charges exceed the \$15.00 per month limit. IAC 78.9(249A)
- d. Plan of care/OASIS is missing, incomplete, or invalid for the dates of service billed.
- e. Physician signature is missing from the plan of care. IAC 78.9(249A) & (1)
- f. The date of the physician signature is untimely. Services were billed prior to physician signing the Plan of care. IAC 78.9(1)

- g. The frequency, duration and number of hours of SN and/or aide visits are not included in the plan of care or physician supplemental orders. IAC 78.9(1) & (7)
- h. The services billed do not match the physician order. IAC 78.9(249A)
- i. Signed physician orders are missing for visits billed. IAC 78.9(249A)
- j. Supervisory visit frequency does not meet Medicaid guidelines. IAC 78.9(2)
- k. Supervisory visits of services provided by a home health aide were not performed at least every two weeks to a member receiving SN, PT, OT or ST. 42CFR 484.36(d)(1)&(2)
- l. Supervisory visits of services provided by a home health aide were not performed at least every 60 days, to a member not receiving SN, PT, OT or ST. 42CFR 484.36(d)(3)
- m. Supervisory visits of home health aide or in-home health related care services exceed the twice a month limit. IAC 78.9(2)
- n. SN visits exceed the five visits per week maximum. IAC 78.9(3)
- o. SN progress notes are missing.
- p. Documentation in skilled nurse progress notes/OASIS does not support the medical necessity of SN. The services provided were not skilled services. IAC 78.9(3)
- q. The member has no underlying or pre-existing medical condition to support medical necessity for SN services to assess/observe/monitor or teach. IAC 78.9(249A) & 78.9(3)
- r. Documentation in aide visit progress notes/OASIS does not support the medical necessity of home health aide services. Personal cares were not provided, member is independent with performing own personal cares, or only housekeeping/homemaker services were provided. IAC 78.9(7)
- s. Home health aide visits exceed the weekly maximum. The number of visits multiplied by the hours per visit cannot exceed 28 hours per week. IAC 78.9(7)c.
- t. Home health aide visit progress notes are missing.
- u. Orders and/or plan of care for physical therapy visits are missing or incomplete. IAC 78.9(4)
- v. Physical therapy progress notes are missing.
- w. Physical therapy visit progress notes do not support medical necessity of PT visits. The member has poor rehab potential or maximum rehab potential has been reached. IAC 78.9(4)
- x. Physical therapy visit progress notes/OASIS does not support medical necessity. Non-skilled personnel can safely carry out services. IAC 78.9(4)
- y. Orders/plan of care for occupational therapy visits is missing or incomplete. IAC 78.9(5)
- z. Occupational therapy progress notes are missing.
- aa. Occupational therapy visit progress notes do not support medical necessity. The member has poor rehab potential or maximum rehab potential has been reached. IAC 78.9(5)
- bb. Occupational Therapy visit progress notes/OASIS does not support medical necessity. Non-skilled personnel can safely carry out services. IAC 78.9(5)
- cc. Orders/plan of care for speech therapy visits is missing or incomplete. IAC 78.9(6)

- dd. Speech therapy progress notes are missing.
- ee. Speech-language therapy visit progress notes do not support medical necessity. The member has poor rehab potential or maximum rehab potential has been reached. IAC 78.9(6)
- ff. Speech-language therapy visit progress notes do not support medical necessity. No material improvement in communication ability was documented. IAC 78.9(6)
- gg. Group ST and audiology services related to the use of a hearing aid are not covered services. IAC 78.9(6)
- hh. Speech therapy visit progress notes do not support medical necessity. Non-skilled personnel can safely carry out services. IAC 78.9(6)
- ii. Documentation in medical social worker visit progress notes/OASIS does not support medical necessity. Evidence of social or emotional factors adversely affecting member's recovery was not present. IAC 78.9(8)a.
- jj. Documentation in medical social worker visit progress notes does not support medical necessity. Visits were made solely to allow a member to air their concerns or to offer reassurance to member. This is not a covered service. IAC 78.9(8)b.

Private Duty Nursing or Personal Care Services Retrospective Recoupment Reasons:

- A. No Concerns
- B. Visits were billed with incorrect Revenue code. IAC 78.9 (249A)
- C. Visits were billed without correct procedure code. IAC 78.9 (249A)
- D. Services were not billed based on a hourly unit of services. 78.9(10)
- E. The services provided were not approved on a prior authorization. 78.9(10)
- F. Plan of Care is missing, incomplete, or invalid for the dates of service billed.
- G. Physician signature is missing from the Plan of Care. IAC 78.9(10)
- H. The date of the physician signature is untimely. The physician signature is not within the certification period. IAC 78.9(1)
- I. The services billed do not match the physician order. IAC 78.9(249A)
- J. Signed physician orders are missing for visits billed. IAC 78.9(249A)
- K. Skilled nursing visit progress notes are missing.
- L. Home Health aid visit progress notes are missing.
- M. Documentation in medical and/or clinical record is incomplete or does not support services billed. Visit notes lack consistent identification of hours billed to payor sources. IAC 79.3(2)
- N. Documentation supports services were provided in a Nursing Facility, Intermediate Care Facility for Intellectually Disabled, or a hospital setting. IAC 78.9(10)
- O. Documentation supports respite services were provided. 78.9(10)
- P. Documentation supports transportation services were provided. IAC 78.9(10)
- Q. Home Health agency services exceed 16 hours of service per day maximum. 78.9(10) and 78.28(9)

Forms/Reports:

Medical Services No Issues Noted Letter

<<Date>>

«performing_provider_address_1»

«performing_provider_address_2»

«performing_provider_city», «performing_provider_state» «performing_provider_zip»

Dear Provider:

Provider Number: «performing_provider_npi»

Iowa Medicaid Enterprise (IME) Home Health Retrospective Medical Review performed a review on the documentation you provided for the Medicaid member identified below. This review was completed to ensure that home health services are provided to Medicaid members within the rules of the Medicaid program as described in Iowa Administrative Code 441-78.9. A determination was made that all services were provided within the rules of the Medicaid program and accurately reimbursed. **The IME is pleased to inform you that no further action is required.**

Member Name: «recipient_last_name», «recipient_first_name» Member ID#: «recipient_ident_number»

Date of Service: «first_service_date» - «last_service_date» TCN: «transaction_control_number»

Thank you for your assistance with this review. If you have any questions regarding this Home Health Retrospective Medical Review, please contact IME Medical Services by calling 800-383-1173, or locally (515) 256-4623.

Medical Services- Home Health Retrospective Medical Review
Iowa Medicaid Enterprise

Medical Services Recoupment Need Identified Letter

September 10, 2010

«performing_provider_address_1»

«performing_provider_address_2»

«performing_provider_city», «performing_provider_state» «performing_provider_zip»

Dear Provider:

Provider NPI:

«performing_provider_npi»

RE: Home Health Services Program–Retrospective Medical Review

Iowa Medicaid Enterprise (IME) Home Health Services Program-Retrospective Medical Review (HHS-RMR) performed a review on the documentation you provided for the Medicaid member identified in the attached HHS-RMR Report. This review was completed to ensure that services are provided to Medicaid members within the rules of the Medicaid Program as described in Iowa Administrative Code 441-78.9. The preliminary findings in this letter and in the attached report indicate that a possible overpayment may have occurred.

This is not a formal notice of overpayment. If you disagree with these preliminary findings, you may request a reevaluation. Per Iowa Administrative Code 441-79.4(5), a request for a reevaluation must:

- **Be submitted in writing within 15 calendar days from the date of this letter.**
- Specify the reason or the specific issues of disagreement.

You may submit clarifying or supplemental documentation that was not previously provided, only if you send a written request for a reevaluation within the 15-day timeframe. Documentation that has previously been submitted may not be re-submitted with changes. The Medical Services Unit must receive the clarifying or supplemental documentation within 30 calendar days of the date of this letter.

Please fax the written request for a reevaluation to 515-725-1355 using the HHS-RMR Fax Cover Form 470-4687 or mail the request to the address identified below:

**Iowa Medicaid Enterprise
Medical Services
P.O. Box 36478
Des Moines, IA 50315
Attention: HHS-RMR**

If you do not elect to request a reevaluation of the preliminary findings, or if you do not submit your reevaluation request in writing within the 15-day timeframe, Medical Services will issue a *Findings and Recoupment* letter, with an overpayment amount provided.

«performing_provider_address_1»

«performing_provider_npi»

September 10, 2010

Review of Potential Issues

This letter describes each issue or area of potential overpayment identified in the preliminary review of the home health services documentation. A report of noted issues with related references to the Iowa Administrative Code is attached to this letter.

The report identifies the claim, member name, state ID, potential issue or concern, date of service, procedure code, number of billed and allowed units, and potential amount of overpayment under consideration associated with the documentation reviewed that does not appear to meet the rules of Iowa Medicaid.

Noted Issues

- «RationaleRevRationaleText»
- «Rationale_1RevRationaleText»
- «Rationale_2RevRationaleText»
- «Rationale_3RevRationaleText»
- «Rationale_4RevRationaleText»
- «Rationale_5RevRationaleText»
- «Rationale_6RevRationaleText»
- «Rationale_7RevRationaleText»
- «Rationale_8RevRationaleText»
- «Rationale_9RevRationaleText»
- «Rationale_10RevRationaleText»
- «Rationale_11RevRationaleText»
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- «Rationale_14RevRationaleText»
- «Rationale_15RevRationaleText»
- «Rationale_16RevRationaleText»
- «Rationale_17RevRationaleText»
- «Rationale_18RevRationaleText»
- «Rationale_19RevRationaleText»
- «Rationale_20RevRationaleText»
- «Rationale_21RevRationaleText»

Summary

If you disagree with these preliminary findings, please respond within **15 calendar days** of the date of this letter with a **written** request for reevaluation specifying the reason or the specific issues of disagreement.

If you have any questions, please contact Medical Services by calling 800-383-1173, or locally (515) 256-4623. If you are providing supplemental documentation as a part of the reevaluation request, this documentation must be received within 30 calendar days of the date of this letter to be considered. Please mail or fax this information as directed on the previous page of this letter.

Medical Services- Home Health Services Program-Retrospective Medical Review
Iowa Medicaid Enterprise

Encl: Home Health Services Program-Retrospective Medical Review Report

Home Health Services Program-Retrospective Medical Review Report
Date:

Provider Name: «performing_provider_address_1» Provider NPI: «performing_provider_npi»
Member Name: «recipient_first_name»
«recipient_last_name» State ID: «recipient_ident_number»
TCN: «transaction_control_number» Date of Service: «first_service_date» -
«last_service_date»
Provider's Submitted Charge: «charge_amount» Medicaid's Original Amount Paid:
«allowed_charge_amount»

Revenue Code	Billed Units	Allowed Units	Potential Recoupment Amount	Review Outcome/Recoupment Reason
«revenue_code_1»	«rev_code_1_units»	«Allowed Units1»	«RecoupAmt1»	«RationaleRevRationaleText» «Rationale_1RevRationaleText» «Rationale_2RevRationaleText»
«revenue_code_2»	«rev_code_2_units»	«Allowed Units2»	«RecoupAmt2»	«Rationale_3RevRationaleText» «Rationale_4RevRationaleText» «Rationale_5RevRationaleText»
«revenue_code_3»	«rev_code_3_units»	«Allowed Units3»	«RecoupAmt3»	«Rationale_6RevRationaleText» «Rationale_7RevRationaleText» «Rationale_8RevRationaleText»
«revenue_code_4»	«rev_code_4_units»	«Allowed Units4»	«RecoupAmt4»	«Rationale_9RevRationaleText» «Rationale_10RevRationaleText» «Rationale_11RevRationaleText»
«revenue_code_5»	«rev_code_5_units»	«Allowed Units5»	«RecoupAmt5»	«Rationale_12RevRationaleText» «Rationale_13RevRationaleText» «Rationale_14RevRationaleText»
«revenue_code_6»	«rev_code_6_units»	«Allowed Units6»	«RecoupAmt6»	«Rationale_15RevRationaleText» «Rationale_16RevRationaleText» «Rationale_17RevRationaleText»
«revenue_code_7»	«rev_code_7_units»	«Allowed Units7»	«RecoupAmt7»	«Rationale_18RevRationaleText»
«revenue_code_8»	«rev_code_8_units»	«Allowed Units8»	«RecoupAmt8»	«Rationale_19RevRationaleText»
«revenue_code_9»	«rev_code_9_units»	«Allowed Units9»	«RecoupAmt9»	«Rationale_20RevRationaleText»
«revenue_code_10»	«rev_code_10_units»	«Allowed Units10»	«RecoupAmt10»	«Rationale_21RevRationaleText»

10»	_units»			
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RFP Reference:

6.2.1
6.2.1.1
6.2.1.2
6.2.1.3

Interfaces:

OnBase

Attachments:

N/A

MED - Home Health Retrospective Review of Clarifying or Supplemental Documentation

Purpose: To allow a provider that received a preliminary findings letter the opportunity to submit clarifying or supplemental information that was not previously submitted. The home health preliminary findings letter allows the provider 15 days to submit a request for reevaluation and 30 days to submit the actual clarifying or supplemental documentation. Any clarifying or supplemental information will be reviewed to determine if recoupment is still necessary.

Identification of Roles:

Review Coordinator (RC) – reviews documentation to determine if the home health services were provided within the rules of the Medicaid Program or if payment needs to be recouped from the provider

Review Assistant (RA) – provides program support through coordinating documentation request letters and supporting review coordinators with accessing information required to complete home health retro reviews.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RA will keyword and log the reevaluation request, clarifying and/or supplemental documentation received from the provider.

Step 2: The RC will review the clarifying and/or supplemental documentation.

Step 3: If the RC determines that the issues have been resolved, the 'Issues Resolved' box is marked in the home health retro database and the RA will send the 'Issues Resolved' letter by mail to the provider informing the provider that no further action is required.

Step 4: If the RC determines that the issues remain and recoupment is needed, the Recoupment Remains-Timely' box is marked.

Step 5: The RA then sends the Recoupment Remains Timely letter by mail to the provider indicating recoupment will occur and appeal rights are given at this time.

Step 6: If there is no request for reevaluation or if the request for reevaluation is received by Medical Services after 15 days from the date of the home health preliminary findings letter, the RA will send the 'Recoupment Remains Untimely' letter which will indicate that overpayment was identified, the Re-evaluation request was not submitted timely and the amount of the overpayment that will be recouped from future claims.

Step 7: If a request for reevaluation is received within the 15 days and no clarifying or supplemental documentation is submitted; or if the clarifying or supplemental documentation is received by Medical Services after 30 days from the date of the home health preliminary findings letter, the RA will send the Recoupment Remains Untimely letter.

- a. This letter will indicate that overpayment was identified, additional information was not submitted timely and the amount of the overpayment that will be recouped from future claims and also gives appeal rights to the provider.

Forms/Reports:

Medical Services Home Health Retro Recoupment Remains Timely Letter

<<date>>

«performing_provider_address_1»

«performing_provider_address_2»

«performing_provider_city», «performing_provider_state» «performing_provider_zip»

Dear Provider:

Provider Number:

«performing_provider_npi»

RE: Home Health Services Program–Retrospective Medical Review

On «ReviewLtr», Iowa Medicaid Enterprise (IME) Medical Services Home Health Services Program-Retrospective Medical Review (HHS-RMR) notified «performing_provider_address_1» that a preliminary finding identified a potential overpayment and that additional information could be submitted for review. The purpose of the review was to ensure that home health services provided to Medicaid members are within the rules of the Medicaid Program.

The following information was submitted in a timely manner:

- ☒ Written request for reevaluation within 15 days.
- ☐ Written request for an extension for submitting a request for reevaluation citing good cause for the extension.
- ☒ Clarifying or supplemental documentation within 30 calendar days.

The above noted information was received within the guidelines of the Iowa Administrative Code 441-79.4. Review of the additional documentation submitted resulted in findings that the previously identified issues were not fully resolved. Medical Services has determined that an overpayment of «**RecoupedAmt**» was made to «performing_provider_address_1», provider number «performing_provider_npi». A claims credit adjustment will be completed to deduct this amount from future claims.

Review of Findings

This letter describes each issue found in the review of the submitted records. The Iowa Administrative Code is the basis and authority for the recoupment associated with the issues found in the records review. A report of issues with related references to the Iowa Administrative Code is attached to this letter. The report identifies the claim and documentation reviewed and the reason for a determination of overpayment when applicable. The above stated amount due is the total recoupment amount identified on the attached report.

«performing_provider_address_1»
«performing_provider_npi»
September 10, 2010

Noted Issues

- «RationaleRevRationaleText»
- «Rationale_1RevRationaleText»
- «Rationale_2RevRationaleText»
- «Rationale_3RevRationaleText»
- «Rationale_4RevRationaleText»
- «Rationale_5RevRationaleText»
- «Rationale_6RevRationaleText»
- «Rationale_7RevRationaleText»
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- «Rationale_13RevRationaleText»
- «Rationale_14RevRationaleText»
- «Rationale_15RevRationaleText»
- «Rationale_16RevRationaleText»
- «Rationale_17RevRationaleText»
- «Rationale_18RevRationaleText»
- «Rationale_19RevRationaleText»
- «Rationale_20RevRationaleText»
- «Rationale_21RevRationaleText»

If Iowa Medicaid Enterprise concludes that an overpayment has occurred resulting from noncompliance with any of the items detailed in IAC 441—79.3(249A) federal regulations, or the Medicaid provider agreement, Iowa Medicaid Enterprise must recover the payment from the Medicaid provider for services billed. You have the right to appeal this decision. Please see the back of this letter to find out how to file an appeal.

Thank you for your assistance with this review. If you have any questions, please contact Medical Services by calling 800-383-1173, or locally (515) 256-4623.

Medical Services- Home Health Services Program-Retrospective Medical Review
Iowa Medicaid Enterprise

Encl: Home Health Services Program-Retrospective Medical Review Report

You Have the Right to Appeal

What is an appeal?

An **appeal** is asking for a hearing because you do not like a decision the Department of Human Services (DHS) makes. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].

How do I appeal?

Filing an appeal is easy. You can appeal in person, by telephone or in writing for Food Assistance or Medicaid. You must appeal in writing for all other programs. To appeal in writing, do **one** of the following:

- Complete an appeal electronically at <https://dhssecure.dhs.state.ia.us/forms/>, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?

For Food Assistance or Medicaid, you have 90 calendar days to file an appeal from the date of a decision. For all other programs, you must file an appeal:

- Within 30 calendar days of the date of a decision **or**
- Before the date a decision goes into effect

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending?

You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal:

- Within 10 calendar days of the date the notice is received. A notice is considered to be received 5 calendar days after the date on the notice **or**
- Before the date a decision goes into effect

Any benefits you get while your appeal is being decided may have to be paid back if the Department's action is correct.

How will I know if I get a hearing?

You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. This letter will tell you why you did not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing?

You or someone else, such as a friend or relative can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county DHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

**Policy Regarding Discrimination, Harassment,
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Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

Home Health Services Program-Retrospective Medical Review Report
Date:

Provider Name: «performing_provider_address_1» Provider NPI: «performing_provider_npi»

Member Name: «recipient_first_name»
«recipient_last_name» State ID: «recipient_ident_number»

TCN: «transaction_control_number» Date of Service: «first_service_date» -
«last_service_date»

Provider's Submitted Charge: «charge_amount» Medicaid's Original Amount Paid:
«allowed_charge_amount»

Total Recoupment Amount: «RecoupedAmt» Medicaid's New Amount Paid: «FinalAmt»

Revenue Code	Billed Units	Allowed Units	Recoupment Amount	Review Outcome/Recoupment Reason
«revenue_code_1»	«rev_code_1_units»	«AllowedUnits1»	«RecoupAmt1»	«RationaleRevRationaleText» «Rationale_1RevRationaleText» «Rationale_2RevRationaleText»
«revenue_code_2»	«rev_code_2_units»	«AllowedUnits2»	«RecoupAmt2»	«Rationale_3RevRationaleText» «Rationale_4RevRationaleText» «Rationale_5RevRationaleText»
«revenue_code_3»	«rev_code_3_units»	«AllowedUnits3»	«RecoupAmt3»	«Rationale_6RevRationaleText» «Rationale_7RevRationaleText» «Rationale_8RevRationaleText»
«revenue_code_4»	«rev_code_4_units»	«AllowedUnits4»	«RecoupAmt4»	«Rationale_9RevRationaleText» «Rationale_10RevRationaleText» «Rationale_11RevRationaleText»
«revenue_code_5»	«rev_code_5_units»	«AllowedUnits5»	«RecoupAmt5»	«Rationale_12RevRationaleText» «Rationale_13RevRationaleText» «Rationale_14RevRationaleText»
«revenue_code_6»	«rev_code_6_units»	«AllowedUnits6»	«RecoupAmt6»	«Rationale_15RevRationaleText» «Rationale_16RevRationaleText» «Rationale_17RevRationaleText»
«revenue_code_7»	«rev_code_7_units»	«AllowedUnits7»	«RecoupAmt7»	«Rationale_18RevRationaleText»
«revenue_code_8»	«rev_code_8_units»	«AllowedUnits8»	«RecoupAmt8»	«Rationale_19RevRationaleText»
«revenue_code_9»	«rev_code_9_units»	«AllowedUnits9»	«RecoupAmt9»	«Rationale_20RevRationaleText»
«revenue_code_10»	«rev_code_10_units»	«AllowedUnits10»	«RecoupAmt10»	

Comments: «Comments»

Medical Services Home Health Retro Recoupment Remains- Untimely Letter

<<date>>

«performing_provider_address_1»

«performing_provider_address_2»

«performing_provider_city», «performing_provider_state» «performing_provider_zip»

Dear Provider:

Provider Number: «performing_provider_npi»

On «ReviewLtr», Iowa Medicaid Enterprise Medical Services Home Health Retrospective Medical Review notified «performing_provider_address_1» that a preliminary finding identified a potential overpayment and that additional information could be submitted for review. The purpose of the review was to ensure that home health services provided to Medicaid members are within the rules of the Medicaid Program.

The following information was not submitted in a timely manner:

- ☐ Written request for reevaluation within 15 days.
- ☐ Written request for an extension for submitting a request for reevaluation citing good cause for the extension.
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The above noted information was not received within the guidelines of the Iowa Administrative Code 441-79.4. Medical Services has determined that an overpayment of «**RecoupedAmt**» was made to «performing_provider_address_1», provider number «performing_provider_npi». A claims credit adjustment will be completed to deduct this amount from future claims.

Review of Findings

This letter describes each issue found in the review of the submitted records. The Iowa Administrative Code is the basis and authority for the recoupment associated with the issues found in the records review. A report of issues with related references to the Iowa Administrative Code is attached to this letter. The report identifies the claim and documentation reviewed and the reason for a determination of overpayment when applicable. The above stated amount due is the total recoupment amount identified on the attached report.

«performing_provider_address_1»
«performing_provider_npi»
August 9, 2010

Noted Issues

- «RationaleRevRationaleText»
- «Rationale_1RevRationaleText»
- «Rationale_2RevRationaleText»
- «Rationale_3RevRationaleText»
- «Rationale_4RevRationaleText»
- «Rationale_5RevRationaleText»
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Medical Services- Home Health Retrospective Medical Review
Iowa Medicaid Enterprise

Encl: Home Health Retrospective Medical Review Report

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Home Health Retrospective Medical Review Report Date:

Provider Name: «performing_provider_address_1» Provider NPI: «performing_provider_npi»
Member Name: «recipient_first_name» State ID: «recipient_ident_number»
«recipient_last_name»
TCN: «transaction_control_number» Date of Service: «first_service_date» - «last_service_date»
Provider's Submitted Charge: «charge_amount» Medicaid's Original Amount Paid: «allowed_charge_amount»
Total Recoupment Amount: «RecoupedAmt» Medicaid's New Amount Paid: «FinalAmt»

Revenue Code	Billed Units	Allowed Units	Recoupment Amount	Review Outcome/Recoupment Reason
«revenue_code_1»	«rev_code_1_units»	«AllowedUnits1»	«RecoupAmt1»	«RationaleRevRationaleText» «Rationale_1RevRationaleText» «Rationale_2RevRationaleText»
«revenue_code_2»	«rev_code_2_units»	«AllowedUnits2»	«RecoupAmt2»	«Rationale_3RevRationaleText» «Rationale_4RevRationaleText» «Rationale_5RevRationaleText»
«revenue_code_3»	«rev_code_3_units»	«AllowedUnits3»	«RecoupAmt3»	«Rationale_6RevRationaleText» «Rationale_7RevRationaleText» «Rationale_8RevRationaleText»
«revenue_code_4»	«rev_code_4_units»	«AllowedUnits4»	«RecoupAmt4»	«Rationale_9RevRationaleText» «Rationale_10RevRationaleText» «Rationale_11RevRationaleText»
«revenue_code_5»	«rev_code_5_units»	«AllowedUnits5»	«RecoupAmt5»	«Rationale_12RevRationaleText» «Rationale_13RevRationaleText» «Rationale_14RevRationaleText»
«revenue_code_6»	«rev_code_6_units»	«AllowedUnits6»	«RecoupAmt6»	«Rationale_15RevRationaleText» «Rationale_16RevRationaleText» «Rationale_17RevRationaleText»

Iowa Department of Human Services
Iowa Medicaid Enterprise (IME)
Medical Services Unit

«revenue_code_7»	«rev_code_7_units»	«AllowedUnits7»	«RecoupAmt7»	«Rationale_18RevRationaleText»
«revenue_code_8»	«rev_code_8_units»	«AllowedUnits8»	«RecoupAmt8»	«Rationale_19RevRationaleText»
«revenue_code_9»	«rev_code_9_units»	«AllowedUnits9»	«RecoupAmt9»	«Rationale_20RevRationaleText»
«revenue_code_10»	«rev_code_10_units»	«AllowedUnits10»	«RecoupAmt10»	«Rationale_21RevRationaleText»
Comments: «Comments»				

Medical Services Home Health Retro Issues Resolved Letter

<<date>>

«performing_provider_address_1»

«performing_provider_address_2»

«performing_provider_city», «performing_provider_state» «performing_provider_zip»

Dear Provider:

Provider Number: «performing_provider_npi»

On «ReviewLtr», Iowa Medicaid Enterprise Medical Services Home Health Retrospective Medical Review notified «performing_provider_address_1» that a preliminary finding identified a potential overpayment and that additional information could be submitted for review of the claim noted below.

Member Name: «recipient_last_name», «recipient_first_name» Member ID#: «recipient_ident_number»

Date of Service: «first_service_date» - «last_service_date» TCN: «transaction_control_number»

The purpose of the review was to ensure that home health services provided to Medicaid members are within the rules of the Medicaid Program. Upon review of the additional information submitted, a determination was made that concerns identified in the preliminary finding were resolved and that recoupment of Medicaid payment is not needed. **IME is pleased to inform you that no further action is required.**

Thank you for your assistance with this review. If you have any questions regarding this Home Health Retrospective Medical Review determination, please contact IME Medical Services by calling 800-383-1173, or locally (515) 256-4623.

Medical Services- Home Health Retrospective Medical Review
Iowa Medicaid Enterprise

Medical Services Retrospective Private Duty/Personal Cares recoupment remains timely letter

<<Date>>

«performing_provider_address_1»

«performing_provider_address_2»

«performing_provider_city», «performing_provider_state» «performing_provider_zip»

Dear Provider:

Provider Number:

«performing_provider_npi»

On «ReviewLtr», Iowa Medicaid Enterprise Medical Services Private Duty Nursing/Personal Cares (PDN/PC) Retrospective Medical Review notified «performing_provider_address_1» that a preliminary finding identified a potential overpayment and that additional information could be submitted for review. The purpose of the review was to ensure that home health services provided to Medicaid members are within the rules of the Medicaid Program.

The following information was submitted in a timely manner:

- ☒ Written request for reevaluation within 15 days.
- ☐ Written request for an extension for submitting a request for reevaluation citing good cause for the extension.

☒ Clarifying or supplemental documentation within 30 calendar days.

The above noted information was received within the guidelines of the Iowa Administrative Code 441-79.4. Review of the additional documentation submitted resulted in findings that the previously identified issues were not fully resolved. Medical Services has determined that an overpayment of «**RecoupedAmt**» was made to «performing_provider_address_1», provider number «performing_provider_npi». A claims credit adjustment will be completed to deduct this amount from future claims.

Review of Findings

This letter describes each issue found in the review of the submitted records. The Iowa Administrative Code is the basis and authority for the recoupment associated with the issues found in the records review. A report of issues with related references to the Iowa Administrative Code is attached to this letter. The report identifies the claim and documentation reviewed and the reason for a determination of overpayment when applicable. The above stated amount due is the total recoupment amount identified on the attached report.

«performing_provider_address_1»
«performing_provider_npi»
July 30, 2013

Noted Issues

- «RationaleRevRationaleText»
- «Rationale_1RevRationaleText»
- «Rationale_2RevRationaleText»
- «Rationale_3RevRationaleText»
- «Rationale_4RevRationaleText»
- «Rationale_5RevRationaleText»
- «Rationale_6RevRationaleText»
- «Rationale_7RevRationaleText»
- «Rationale_8RevRationaleText»
- «Rationale_9RevRationaleText»
- «Rationale_10RevRationaleText»
- «Rationale_11RevRationaleText»
- «Rationale_12RevRationaleText»
- «Rationale_13RevRationaleText»
- «Rationale_14RevRationaleText»
- «Rationale_15RevRationaleText»
- «Rationale_16RevRationaleText»
- «Rationale_17RevRationaleText»
- «Rationale_18RevRationaleText»
- «Rationale_19RevRationaleText»
- «Rationale_20RevRationaleText»
- «Rationale_21RevRationaleText»

If Iowa Medicaid Enterprise concludes that an overpayment has occurred resulting from noncompliance with any of the items detailed in IAC 441—79.3(249A) federal regulations, or the Medicaid provider agreement, Iowa Medicaid Enterprise must recover the payment from the Medicaid provider for services billed. You have the right to appeal this decision. Please see the back of this letter to find out how to file an appeal.

Thank you for your assistance with this review. If you have any questions, please contact Medical Services by calling 800-383-1173, or locally (515) 256-4623.

Medical Services- PDN/PC Retrospective Medical Review
Iowa Medicaid Enterprise

Encl: PDN/PC Retrospective Medical Review Report

You Have the Right to Appeal

What is an appeal?

An **appeal** is asking for a hearing because you do not like a decision the Department of Human Services (DHS) makes. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].

How do I appeal?

Filing an appeal is easy. You can appeal in person, by telephone or in writing for Food Assistance or Medicaid. You must appeal in writing for all other programs. To appeal in writing, do **one** of the following:

- Complete an appeal electronically at <https://dhssecure.dhs.state.ia.us/forms/>, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?

For Food Assistance or Medicaid, you have 90 calendar days to file an appeal from the date of a decision. For all other programs, you must file an appeal:

- Within 30 calendar days of the date of a decision or
- Before the date a decision goes into effect

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending?

You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal:

- Within 10 calendar days of the date the notice is received. A notice is considered to be received 5 calendar days after the date on the notice or
- Before the date a decision goes into effect

Any benefits you get while your appeal is being decided may have to be paid back if the Department's action is correct.

How will I know if I get a hearing?

You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. This letter will tell you why you did not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing?

You or someone else, such as a friend or relative can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county DHS office can give you information about legal services. The cost of

legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

Home Health Retrospective Medical Review Report Date:

Provider Name: «performing_provider_address_1»	Provider NPI: «performing_provider_npi»
Member Name: «recipient_first_name» «recipient_last_name»	State ID: «recipient_ident_number»
TCN: «transaction_control_number»	Date of Service: «first_service_date» - «last_service_date»
Provider's Submitted Charge: «charge_amount»	Medicaid's Original Amount Paid: «allowed_charge_amount»
Total Recoupment Amount: «RecoupedAmt»	Medicaid's New Amount Paid: «FinalAmt»

Revenue Code	Billed Units	Allowed Units	Recoupment Amount	Review Outcome/Recoupment Reason
«revenue_code_1»	«rev_code_1_units»	«Allowed Units1»	«RecoupAmt1»	«RationaleRevRationaleText» «Rationale_1RevRationaleText» «Rationale_2RevRationaleText»
«revenue_code_2»	«rev_code_2_units»	«Allowed Units2»	«RecoupAmt2»	«Rationale_3RevRationaleText» «Rationale_4RevRationaleText» «Rationale_5RevRationaleText»
«revenue_code_3»	«rev_code_3_units»	«Allowed Units3»	«RecoupAmt3»	«Rationale_6RevRationaleText» «Rationale_7RevRationaleText» «Rationale_8RevRationaleText»
«revenue_code_4»	«rev_code_4_units»	«Allowed Units4»	«RecoupAmt4»	«Rationale_9RevRationaleText» «Rationale_10RevRationaleText»

code_4»	units»	Units4»		«Rationale_11RevRationaleText»
«revenue_code_5»	«rev_code_5_units»	«Allowed Units5»	«RecoupAmt5»	«Rationale_12RevRationaleText» «Rationale_13RevRationaleText» «Rationale_14RevRationaleText»
«revenue_code_6»	«rev_code_6_units»	«Allowed Units6»	«AllowedUnits6»	«Rationale_15RevRationaleText» «Rationale_16RevRationaleText» «Rationale_17RevRationaleText»
«revenue_code_7»	«rev_code_7_units»	«Allowed Units7»	«RecoupAmt7»	«Rationale_18RevRationaleText»
«revenue_code_8»	«rev_code_8_units»	«Allowed Units8»	«RecoupAmt8»	«Rationale_19RevRationaleText»
«revenue_code_9»	«rev_code_9_units»	«Allowed Units9»	«RecoupAmt9»	«Rationale_20RevRationaleText»
«revenue_code_10»	«rev_code_10_units»	«Allowed Units10»	«RecoupAmt10»	«Rationale_21RevRationaleText»
Comments: «Comments»				

Medical Services Retrospective Private Duty/Personal Cares Issues Resolved Letter

<<Date>>

«performing_provider_address_1»
«performing_provider_address_2»
«performing_provider_city», «performing_provider_state» «performing_provider_zip»

Dear Provider:

Provider Number:

«performing_provider_npi»

On «ReviewLtr», Iowa Medicaid Enterprise (IME) Medical Services Private Duty Nursing/Personal Cares (PDN/PC) Retrospective Medical Review notified «performing_provider_address_1» that a preliminary finding identified a potential overpayment and that additional information could be submitted for review of the claim noted below.

Member Name: «recipient_last_name», «recipient_first_name» Member ID#: «recipient_ident_number»

Date of Service: «first_service_date» - «last_service_date» TCN: «transaction_control_number»

The purpose of the review was to ensure that PDN/PC services provided to Medicaid members are within the rules of the Medicaid Program. Upon review of the additional information submitted, a determination was made that concerns identified in the preliminary finding were resolved and that recoupment of Medicaid payment is not needed. **IME is pleased to inform you that no further action is required.**

Thank you for your assistance with this review. If you have any questions regarding this PDN/PC Retrospective Medical Review determination, please contact IME Medical Services by calling 800-383-1173, or locally (515) 256-4623.

Medical Services- PDN/PC Retrospective Medical Review
Iowa Medicaid Enterprise

Medical Services Retrospective Private Duty Nursing/Personal Cares No Issues Noted Letter

<<Date>>

«prov_name»
«performing_provider_address_1»
«performing_provider_address_2»
«performing_provider_city», «performing_provider_state» «performing_provider_zip»

Dear Provider: Provider Number: «performing_provider_npi»

Iowa Medicaid Enterprise (IME) Private Duty Nursing/Personal Cares (PDN/PC) Retrospective Medical Review performed a review on the documentation you provided for the Medicaid member identified below. This review was completed to ensure that PDN/PC services are provided to Medicaid members within the rules of the Medicaid program as described in Iowa Administrative Code 441-78.9. A determination was made that all services were provided within the rules of the Medicaid program and accurately reimbursed. **IME is pleased to inform you that no further action is required.**

Member Name: «recipient_last_name», «recipient_first_name» Member ID#: «recipient_id_number»

Date of Service: «first_service_date» - «last_service_date» TCN: «transaction_control_number»

Thank you for your assistance with this review. If you have any questions regarding this PDN/PC Retrospective Medical Review, please contact IME Medical Services by calling 800-383-1173, or locally (515) 256-4623.

Medical Services- PDN/PC Retrospective Medical Review
Iowa Medicaid Enterprise

Medical Services Retrospective Private Duty Nursing/Personal Cares Recoupment Need Identified Letter

<<Date>>

«prov_name»

«performing_provider_address_2»

«performing_provider_city», «performing_provider_state» «performing_provider_zip»

Dear Provider:

Provider NPI:

«performing_provider_npi»

Iowa Medicaid Enterprise (IME) Private Duty Nursing/Personal Cares (PDN/PC) Retrospective Medical Review performed a review on the documentation you provided for the Medicaid member identified on the attached PDN/PC Retrospective Medical Review Report. This review was completed to ensure that services are provided to Medicaid members within the rules of the Medicaid Program as described in Iowa Administrative Code 441-78.9. The preliminary findings in this letter and in the attached report indicate that a possible overpayment may have occurred.

This is not a formal notice of overpayment. If you disagree with these preliminary findings, you may request a reevaluation. Per Iowa Administrative Code 441-79.4(5), a request for a reevaluation must:

- **Be submitted in writing within 15 calendar days from the date of this letter.**
- Specify the reason or the specific issues of disagreement.

You may submit clarifying or supplemental documentation that was not previously provided, only if you send a written request for a reevaluation within the 15-day timeframe. Documentation that has previously been submitted may not be re-submitted with changes. The Medical Services Unit must receive the clarifying or supplemental documentation within 30 calendar days of the date of this letter.

Please fax the written request for a reevaluation to 515-725-1355 using the PDN/PC Retrospective Medical Review Fax Cover Form 470-4687 or mail the request to the address identified below:

**Iowa Medicaid Enterprise
Medical Services
P.O. Box 36478
Des Moines, IA 50315
Attention: PDN/PC Retrospective Medical Review**

If you do not elect to request a reevaluation of the preliminary findings, or if you do not submit your reevaluation request in writing within the 15-day timeframe, Medical Services will issue a *Findings and Recoupment* letter, with an overpayment amount provided.

«performing_provider_address_1»

«performing_provider_npi»

July 30, 2013

Review of Potential Issues

This letter describes each issue or area of potential overpayment identified in the preliminary review of the home health services documentation. A report of noted issues with related references to the Iowa Administrative Code is attached to this letter.

The report identifies the claim, member name, state ID, potential issue or concern, date of service, procedure code, number of billed and allowed units, and potential amount of overpayment under consideration associated with the documentation reviewed that does not appear to meet the rules of Iowa Medicaid.

Noted Issues

- «RationaleRevRationaleText»
- «Rationale_1RevRationaleText»
- «Rationale_2RevRationaleText»
- «Rationale_3RevRationaleText»
- «Rationale_4RevRationaleText»
- «Rationale_5RevRationaleText»
- «Rationale_6RevRationaleText»
- «Rationale_7RevRationaleText»
- «Rationale_8RevRationaleText»
- «Rationale_9RevRationaleText»
- «Rationale_10RevRationaleText»
- «Rationale_11RevRationaleText»
- «Rationale_12RevRationaleText»
- «Rationale_13RevRationaleText»
- «Rationale_14RevRationaleText»
- «Rationale_15RevRationaleText»
- «Rationale_16RevRationaleText»
- «Rationale_17RevRationaleText»
- «Rationale_18RevRationaleText»
- «Rationale_19RevRationaleText»
- «Rationale_20RevRationaleText»
- «Rationale_21RevRationaleText»

Summary

If you disagree with these preliminary findings, please respond within **15 calendar days** of the date of this letter with a **written** request for reevaluation specifying the reason or the specific issues of disagreement.

If you have any questions, please contact Medical Services by calling 800-383-1173, or locally (515) 256-4623. If you are providing supplemental documentation as a part of the reevaluation request, this documentation must be received within 30 calendar days of the date of this letter to be considered. Please mail or fax this information as directed on the previous page of this letter.

Medical Services- PDN/PC Retrospective Medical Review
Iowa Medicaid Enterprise

Encl: PDN/PC Retrospective Medical Review Report

PDN/PC Retrospective Medical Review Report
Date:

Provider Name:
«performing_provider_address_1»

Provider NPI:
«performing_provider_npi»

Member Name: «recipient_first_name»
«recipient_last_name»

State ID: «recipient_ident_number»

TCN: «transaction_control_number»

Date of Service: «first_service_date»
- «last_service_date»

Provider's Submitted Charge: «charge_amount»

Medicaid's Original Amount Paid:
«allowed_charge_amount»

Revenue Code	Billed Units	Allowed Units	Potential Recoupment Amount	Review Outcome/Recoupment Reason
«revenue_code_1»	«rev_code_1_units»	«AllowedUnits1»	«RecoupAmt1»	«RationaleRevRationaleText» «Rationale_1RevRationaleText» «Rationale_2RevRationaleText»
«revenue_code_2»	«rev_code_2_units»	«AllowedUnits2»	«RecoupAmt2»	«Rationale_3RevRationaleText» «Rationale_4RevRationaleText» «Rationale_5RevRationaleText»
«revenue_code_3»	«rev_code_3_units»	«AllowedUnits3»	«RecoupAmt3»	«Rationale_6RevRationaleText» «Rationale_7RevRationaleText» «Rationale_8RevRationaleText»
«revenue_code_4»	«rev_code_4_units»	«AllowedUnits4»	«RecoupAmt4»	«Rationale_9RevRationaleText» «Rationale_10RevRationaleText» «Rationale_11RevRationaleText»
«revenue_code_5»	«rev_code_5_units»	«AllowedUnits5»	«RecoupAmt5»	«Rationale_12RevRationaleText» «Rationale_13RevRationaleText» «Rationale_14RevRationaleText»
«revenue_code_6»	«rev_code_6_units»	«AllowedUnits6»	«RecoupAmt6»	«Rationale_15RevRationaleText» «Rationale_16RevRationaleText» «Rationale_17RevRationaleText»

«revenue_code_7»	«rev_code_7_units»	«AllowedUnits7»	«RecoupAmt7»	«Rationale_18RevRationaleText»
«revenue_code_8»	«rev_code_8_units»	«AllowedUnits8»	«RecoupAmt8»	«Rationale_19RevRationaleText»
«revenue_code_9»	«rev_code_9_units»	«AllowedUnits9»	«RecoupAmt9»	«Rationale_20RevRationaleText»
«revenue_code_10»	«rev_code_10_units»	«AllowedUnits10»	«RecoupAmt10»	«Rationale_21RevRationaleText»
Comments: «Comments»				

RFP Reference:

6.2.1
6.2.1.1
6.2.1.2
6.2.1.3

Interfaces:

OnBase

Attachments:

N/A

MED - Home Health Retrospective Review Completing a Credit or Adjustment Request

Purpose: Complete a credit and/or an adjustment request after it has been determined that recoupment is necessary.

Identification of Roles:

Review Coordinator (RC) – reviews documentation to determine if the home health service were provided within the rules of the Medicaid program and completes a credit and/or adjustment request if payment needs to be recouped from the provider

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: When a recoupment need is identified, the RC will review claims history in MMIS and verify the provider has not already submitted a credit and/or adjustment request for appropriate payment and enter the credit adjustment into OnBase.

Step 2: The RC will enter the date the credit and/or adjustment was submitted into the home health retro data base.

Step 3: If the provider has indicated in their reevaluation request that they will submit an adjustment or if the provider has already submitted an adjustment, the date the adjustment processes is entered into the home health retro data base.

Step 4: The RC verifies the credit and/or adjustment the provider submits correlates with the RC review results of the documentation.

Forms/Reports:

N/A

RFP Reference:

6.2.1

6.2.1.1

6.2.1.2

6.2.1.3

Interfaces:

OnBase

Attachments:

N/A

MED - Home Health Retrospective Review Internal Quality Control Process

Purpose: To provide continuous quality improvement to the home health retrospective medical review functions and meet all performance standards.

Internal Quality Control (IQC) is a peer-to-peer review process completed monthly on 15 home health reviews completed by each reviewer from the previous month.

Identification of Roles:

Review Coordinator (RC) – performs IQC review on assigned home health reviews

Lead Review Coordinator (LRC) – distributes and tracks the retro IQC reviews and provides follow-up on quality concerns

Manager – reviews results of IQC reviews and assists with follow-up on any quality concerns

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: The LRC randomly selects 15 home health retro reviews out of the MED07 Completed Queue for each RC that reviewed home health claims the previous month.

Step 2: The LRC enters the document control number (DCN) for each completed review in an excel spreadsheet and distributes by email to the assigned reviewer.

Step 3: The RC has four questions on the IQC spreadsheet to address for each DCN reviewed.

Step 4: The RC must complete internal quality control (IQC) within 15 business days of receipt of DCN list from LRC.

Step 5: The RC documents on the excel spreadsheet if the review was completed appropriately and any issues noted.

Step 6: The RC emails the home health review IQC to the LRC.

Step 7: The LRC re-reviews any noted issues and follows-up with the RC who performed the original claims review and resolves any outstanding issues.

b. The LRC will involve the manager in this process as needed.

Step 8: The LRC calculates the accuracy percentage and inputs this information along with the number of home health reviews reviewed on the Team IQC tracking log located in the Med Srv Reports Drive>Claims Reporting folder and informs the manager of any outstanding issues.

Step 9: Manager reviews the Team IQC tracking log to ensure the process is completed in a timely manner and works with the LRC on any quality concerns.

Forms/Reports:

Home health retrospective review calculations in the quarterly narrative report submitted to DHS as well as the annual report card.

RFP Reference:

6.2.1

6.2.1.1

6.2.1.2

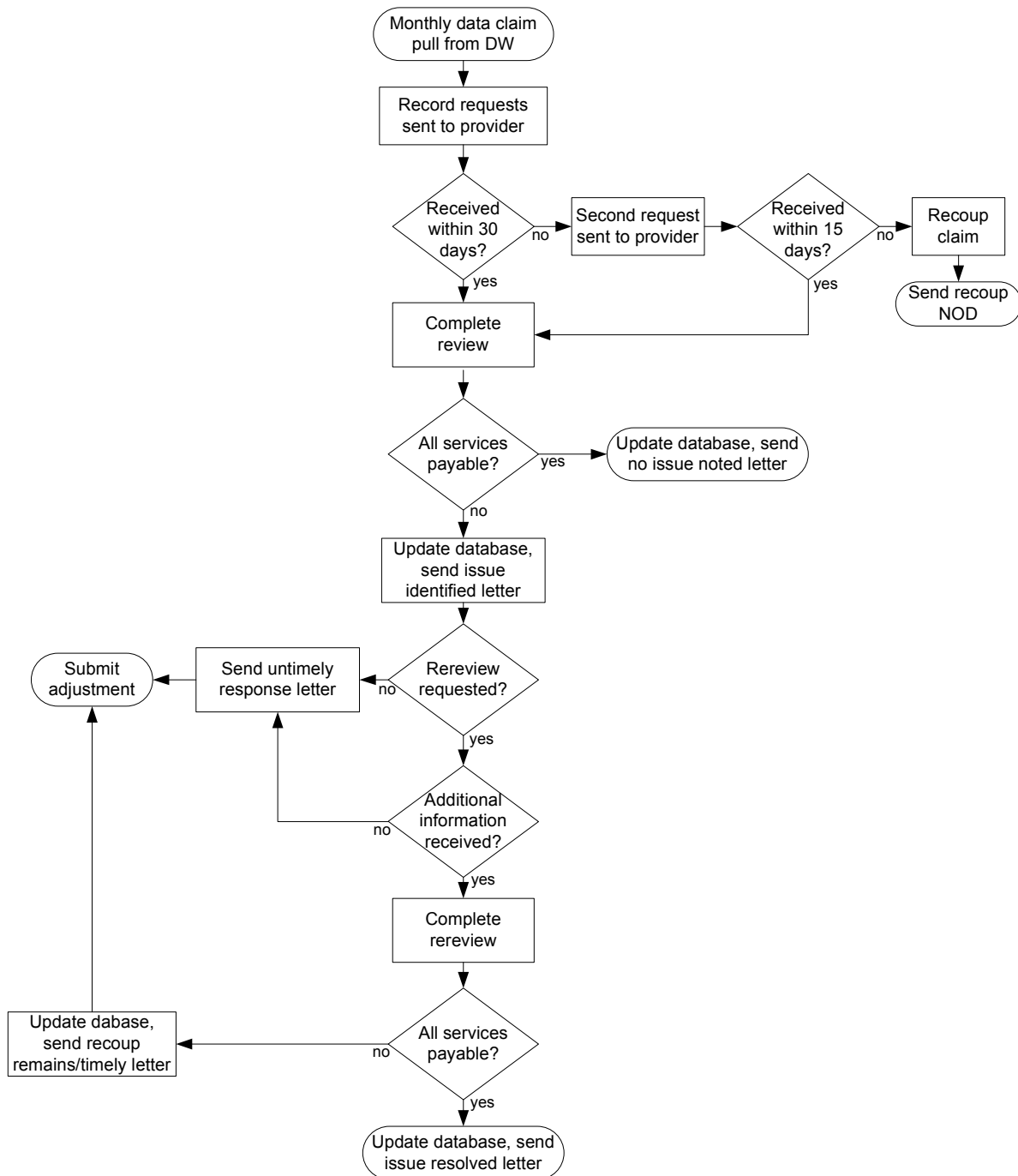
6.2.1.3

Interfaces:

OnBase

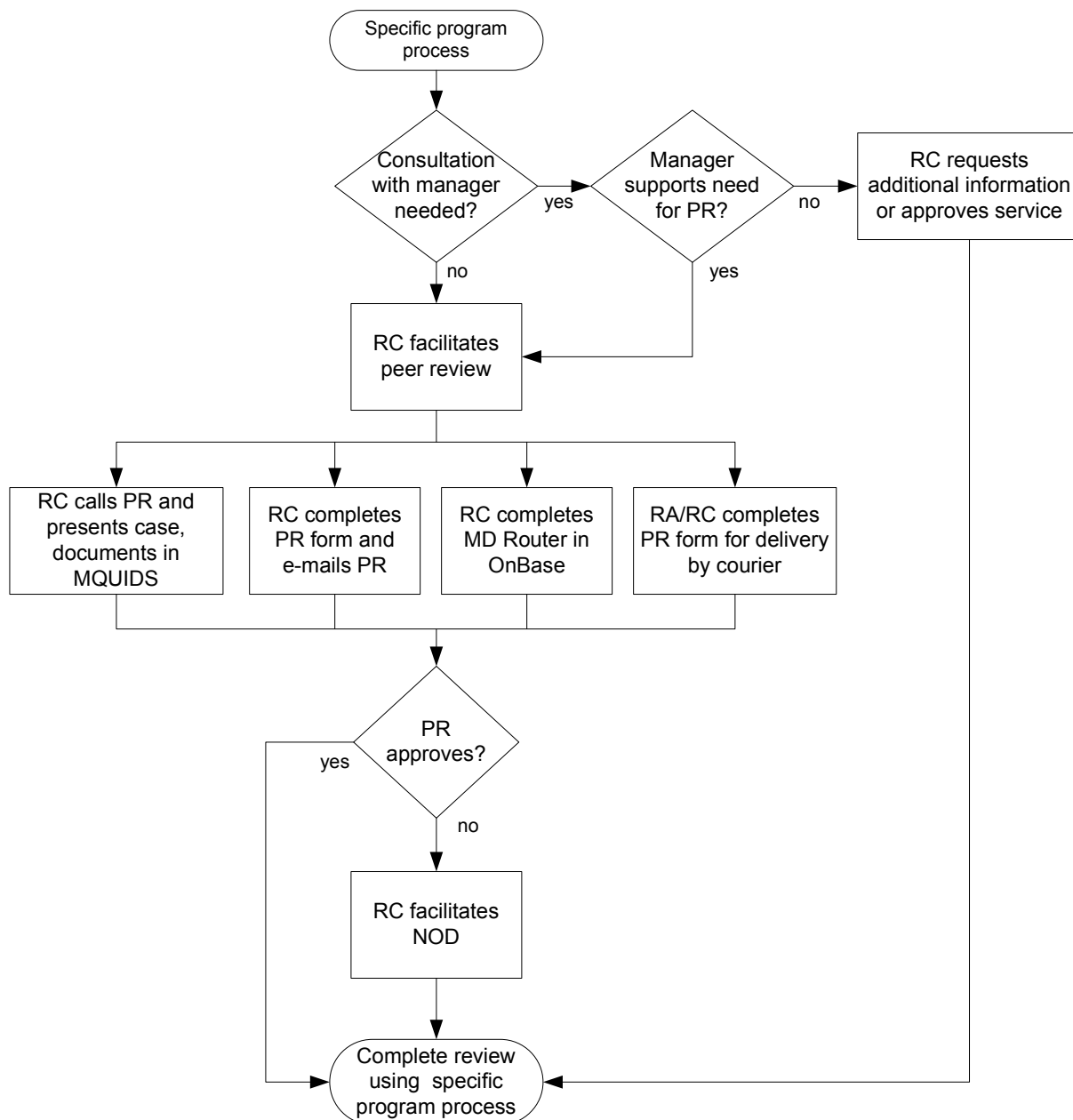
Attachment A:

Home Health Retrospective Review



Attachment B:

Peer Review



Attachment C:

ADMINISTRATIVE LAW JUDGE APPEALS

